Form G

Stockbridge-Munsee Community | Electa Quinney Head Start
CHILD CARE ENROLLMENT, HEALTH HISTORY, EMERGENCY CARE PLAN, AND PERMISSION

Instructions: The parent / guardian should complete this form for placement in child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review/update the information provided on this form.

Child's Full Name **Date of Birth**
Address **Telephone**

Parent/Guardian Name
Address
Telephone **Work**
Message

EMERGENCY CONTACT/AUTHORIZED PERSONS INFORMATION

Authorized to Pick Up/Drop Off Child to/from Head Start at W13429 Cherry Street Bowler, WI 54416

- **Emergency Contact A**

Name **Relationship to Child**
Telephone **Work**
Message

☐ **I have spoken with (EMERGENCY CONTACT A) and they are aware they may be called at any time if Head Start is unable to reach me and my child is sick or unable to remain at Head Start for any reason and must be picked up.**

- **Emergency Contact B**

Name **Relationship to Child**
Telephone **Work**
Message

☐ **I have spoken with (EMERGENCY CONTACT B) and they are aware they may be called at any time if Head Start is unable to reach me and my child is sick or unable to remain at Head Start for any reason and must be picked up.**

Emergency Contact C

Name **Relationship to Child**
Telephone **Work**
Message

☐ **I have spoken with (EMERGENCY CONTACT C) and they are aware they may be called at any time if Head Start is unable to reach me and my child is sick or unable to remain at Head Start for any reason and must be picked up.**

Procedure to Follow When Parent/Guardian or Authorized Adult is Not Available to Receive Child

Form G

PHYSICIAN INFORMATION

Physician Name **Medical Facility**

Telephone

HEALTH HISTORY AND EMERGENCY CARE PLAN

As available, please attach any health care plan information from child's physician, therapist etc.

☐ **- No Specific Medical Condition(s)** ☐ **- Epilepsy/Seizure Disorder**

☐ **- Asthma** ☐ **- Cerebral Palsy / Motor Disorder**

☐ **- Any Disorder Including Cognitive Disability (LD, ADD, ADHD, or Autism)**

☐ **- Gastrointestinal or feeding concerns including special diet and supplements**

☐ **- Milk Allergy If child is allergic to milk please include a statement from the medical professional indicating acceptable alternative(s)**

☐ **- Non-Food Allergies Please list**

☐ **Triggers that may Cause Problems**

☐ **Signs or Symptoms to Watch for**

Steps Child Care Provider Should Follow

***If medications are necessary, a copy of the Authorization to Administer Medication Must be Attached.**

(A copy can be requested from the office.)

When to Call Parents Regarding Symptoms or Failure to Respond to Treatment

When to Consider the Condition Requires Emergency Medical Care or Reassessment

Additional Information that may be Helpful to the Child Care Provider

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AUTHORIZATIONS

☐ - Yes ☐ - No I Hereby Give My Consent for Emergency Medical Care or Treatment to be Used Only if I Cannot be Reached Immediately

☐ - Yes ☐ - No I Hereby Give My Consent for My Preschool-Aged Child to Enter a Building Unescorted

☐ - Yes ☐ - No I Have Had an Opportunity to Review the Policies of this Child Care Center (Electa Quinney Head Start) and a Summary of the WI Licensing Rules

Parent Signature: **Date:**